ADULT HISTORY FORM

Please complete this form and return it prior to your scheduled neuropsychological assessment appointment. Thank you.

Name: _____ **Date of Birth**: _____

Who referred you for the current evaluation? _____

Have you ever had a neuropsychological evaluation in the past? (Yes / No)
(if yes, when? _____ Name of neuropsychologist _____
Please bring along a copy of the report from this evaluation, if you have it

What is your understanding of why they referred you for this current evaluation?

_____
_____
_____
_____

What are the questions that you would like the current evaluation to address?

1. _____
_____
_____
_____

2. _____
_____
_____
_____

3. _____
_____
_____
_____

If you have any problems with your thinking, memory, concentration, language, mood, etc., which problems are the **most bothersome** to you right now?

_____
_____

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When did you **first start to notice** that you had these symptoms?

_____
_____
_____

Do you think that these symptoms have gotten **worse**, **better**, or **stayed the same?**

_____
_____
_____

If they have gotten worse over time, has the process been **gradual** or **sudden?**

_____
_____

Are your symptoms **interfering with your day-to-day functioning**? If so, please give examples (*at work/school, at home, in relationships, in your ability to care for yourself, driving, etc.*)

_____
_____
_____
_____
_____

What did you **used to be able to do** that you can no longer do because of your current symptoms?

_____
_____
_____
_____

What types of strategies do you currently use to compensate for your cognitive difficulties? (*for example: calendar, Palm Pilot/PDA, sticky notes, lists, reminders from family members/friends, pillbox, etc.*)

_____
_____
_____
_____

Medical History:

Please check if you have a history of any of the following

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart Attack
- ☐ Cancer (if yes, what kind?_____)
- ☐ Infectious disease (if yes, what kind?_____)
- ☐ Autoimmune disease (if yes, what kind?_____)
- ☐ Diabetes
- ☐ Lung disease
- ☐ Stomach disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Arthritis
- ☐ Prolonged infection
- ☐ HIV
- ☐ Hepatitis B or C
- ☐ Lyme disease
- ☐ Head injury (with loss of consciousness? Yes/No)
- ☐ Stroke
- ☐ Brain tumor
- ☐ Seizure
- ☐ Hydrocephalus
- ☐ Tourette's Syndrome/Tics
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Migraines
- ☐ Sleep apnea
- ☐ Restless leg syndrome
- ☐ Dementia
- ☐ Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Tremor
- ☐ Attention Deficit Disorder
- ☐ Learning Disability
- ☐ Major Depression
- ☐ Electroconvulsive Therapy
- ☐ Psychiatric Hospitalization
- ☐ Suicide Attempt
- ☐ Anxiety Disorder
- ☐ Psychotic Disorder
- ☐ Alcohol Abuse
- ☐ Drug Abuse

Are you currently in treatment for any of the above conditions? (Y/N) If yes, with whom? _____
Have you ever been hospitalized? (Y/N)
Have you ever had a ☐ Head CT scan ☐ Brain MRI scan ☐EEG ☐ Lumbar puncture ☐ SPECT scan ☐ PET scan
Who is your primary care physician?_____

(For women only) Are you post-menopausal? (Y/N) Are you currently going through menopause (Y/N)

Psychiatric History and Status:

Are you currently in psychiatric treatment?_____

Are you receiving psychotherapy?_____

Have you ever been treated with psychotropic medications (medications to treat mood)?_____

Other relevant notes pertaining to your psychiatric history:_____

Currently, would you describe your mood as (circle one or more):
sad, happy, angry, anxious, apathetic, neutral or other_____

Current Symptoms: *Check if you **currently** experience any of the following:*

☐Sleep problems
- ☐ Trouble falling asleep
- ☐ Trouble sleeping through the night
- ☐ Waking up early in the morning and unable to fall back asleep
- ☐ Snoring
- ☐ Periods of no breathing during sleep

☐ Trouble with driving
☐ Headaches
☐ Pain (*where?_____ how often?_____)*
☐ Vision problems
- ☐ Wear glasses/contacts for reading
- ☐ Wear glasses/contacts for distance
- ☐ Cataracts / Glaucoma / Macular degeneration
- ☐ Other *(please describe_____)*

☐ Hearing problems (wear hearing aides? Yes/No)
☐ Color blindness
☐ Trouble with sense of smell
(when did this start?_____)
☐ Trouble with sense of taste
(when did this start?_____)
☐ Tingling or numbness in body
(where?_____)

☐ Balance problems
☐ Weakness
☐ Dizziness
☐ Stomach problems (upset stomach / acid reflux / poor appetite)
☐ Lack of interest in things that used to be pleasurable
☐ Crying more often than usual (or feeling like crying)
☐ Seeing things that aren't there/that others can't see
(if yes, please describe: _____
_____)
☐ Hearing things that aren't there/that others can't hear
(if yes, please describe: _____
_____)
☐ Lethargy/Fatigue
☐ Feelings of guilt
☐ Feelings of worthlessness
☐ Thoughts of self-harm
☐ Feeling that it is hard to go on living

Current Medications: *feel free to attach a copy of your medication list*

Medication	Dosage	For which condition?

Health Behaviors:

Do you currently drink alcohol? **Y/N** *(If yes, approximately how many drinks per day?____Per week?___)*
Have you ever been treated in the past for alcohol use or dependence? (*if yes, when?_____)*
Do you currently use any illicit drugs? **Y/N** (If yes, please list names below, with frequency)

_____

Do you currently use caffeine regularly? **Y/N** (for example, in coffee, tea, chocolate). If yes, how much per day?

_____

Do you exercise regularly? **Yes/No** If Yes, how often and for how long? _____
What type of exercise? _____

Do you smoke? **Yes/No** If Yes, how many packs per day? _____ How long have you smoked?____

What time do you usually get to bed at night? _____
What time do you usually wake up? _____

Do you eat a balanced diet? **Yes/No** How many meals a day do you eat? (circle one) **1** / **2** / **3** / **3 +**
Do you tend to eat a lot of sugar during the day? **Yes/No**
Do you eat fruits and vegetables every day? **Yes/No**
Have you ever seen a nutritionist? **Yes/No**

Do you use mind/body techniques on a regular basis? **Yes/No**
(for example: deep breathing, yoga, biofeedback, meditation)

Do you receive any alternative/non-Western therapies on a regular basis? **Yes/No**
(for example: acupuncture, massage, herbal medicine, etc)

Family Medical History:

	Currently living?	*Current age (or age when deceased)*	*Any problems with memory, concentration, thinking, or behavior? (If deceased, any problems when alive?)*
Mother	Yes/No		
Father	Yes/No		

Brothers/Sisters: Please list all brothers and sisters

Age	*M/F*	*Currently living?*	*Any problems with memory or thinking?*
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	

Does/did anyone in your biological family have any of the following?

☐ **Neurological illness or Dementia**
- ☐ Alzheimer's disease (*if yes, who?*_____)
- ☐ Parkinson's disease (*if yes, who?*_____)
- ☐ Another type of dementia (*What type?*_____W*ho?*_____)
- ☐ Multiple Sclerosis or Lupus (*if yes, who?*_____)
- ☐ Epilepsy (*if yes, who?*_____)

☐ **Heart Disease or Stroke**
- ☐ Stroke (*if yes, who?*_____)
- ☐ Aneurysm (*if yes, who?*_____)
- ☐ Heart Attack (*if yes, who?*_____)
- ☐ TIAs / "small strokes" / "mini-strokes" (*if yes, who?*_____)

☐ **Developmental Disorder / Learning Disability**
- ☐ Attention Deficit Hyperactivity Disorder (ADD, ADHD) (*if yes, who?*_____)
- ☐ Reading Problems or Dyslexia (*if yes, who?*_____)
- ☐ Other Speech or Language Problem (*if yes, who?*_____)
- ☐ Mental Retardation (*if yes, who?*_____)
- ☐ Autism or Asperger's Syndrome (*if yes, who?*_____)

☐ **Mood disorder, Anxiety disorder, Substance abuse**
- ☐ Depression (*if yes, who?*_____)
- ☐ Anxiety (*if yes, who?*_____)
- ☐ Tourette's Syndrome (*if yes, who?*_____)
- ☐ Bipolar Disorder or Manic Depression (*if yes, who?*_____)
- ☐ Schizophrenia (*if yes, who?*_____)
- ☐ Alcoholism (*if yes, who?*_____)
- ☐ Drug abuse (*if yes, who?*_____)
- ☐ Other psychiatric illness (*if yes, who?*_____)

Developmental, Educational and Vocational History:

Where were you born? _____

Where did you grow up? _____

Is English your first language? (If no, what is your native language?_____)
Were there any complications during your mother's pregnancy with you (Y/N) or your birth (Y/N)?
(if yes, what were the complications? _____)

Are you ☐ right-handed ☐ left-handed ☐ ambidextrous (right and left handed)
** ☐ *did you start out left-handed and become right-handed later on?*
** *If left-handed, are any other family members also left-handed?*

Check if you were *late* in any of these areas compared to other children your age:

☐ Crawling
☐ Walking
☐ Talking
☐ Reading
☐ Writing
☐ Riding a bicycle

What is the highest level of education that you have achieved?

☐ Pre-high school ☐ High School ☐ Associates Degree ☐ B.A. from 4-year college
☐ Master's Degree ☐ Doctoral Degree ☐ Other professional degree _____

Where did you go to:

High school _____ (any problems noted?)
College/University_____(any problems noted?)
Graduate school _____(any problems noted?)

What were your average grades during the following stages of your education (*circle*):

Elementary School:	A	B	C	D	F
High School:	A	B	C	D	F
College/University:	A	B	C	D	F
Graduate School:	A	B	C	D	F

Academic Difficulties: Check if any of the following were true for you:

☐ Held back a grade in school
☐ Tested for special education
☐ Received special education services (i.e. speech therapy, help in reading, tutoring, etc…)
☐ Poor grades
☐ Difficulty with math
☐ Difficulty with writing
☐ Difficulty with spelling
☐ Difficulty reading
☐ Received negative comments (eg, "Class clown" or "Does not work to potential")

What type of occupational work have you done in the past?

_____

What type of occupational work are you doing currently?

_____

Are you currently retired? Yes /No (If yes, when did you retire? _____ Why? _____)

Are you currently on disability? Yes/ No / Applying (If yes, for what reason? _____)

Have you ever received negative feedback from supervisors at work or school becasue of your current symptoms? _____

Current Context:

What is your current living situation? ☐ Alone ☐ With partner/spouse ☐ With roommates ☐ With other family ☐ With friends

Family:

Are you currently in a relationship with a partner/spouse? (Y/N)

Are you currently separated or divorced from a partner/spouse or a widow/widower? (Y/N)

Do you have children? (Y/N) *If yes, please list ages:*

Age	**M/F**	**Living at home?**	**Any health or learning problems?**

Access to healthcare: Do you have adequate access to healthcare at the present time? (Y/N)
(If no, please elaborate _____)

Psychosocial supports: Do you have adequate emotional support from others around you? (Y/N) Where do you look for support in your community? (*i.e. partner/spouse, family, colleagues, friends, religious organization*)

_____

Stressors: How would you rate your current level of stress (*none/mild/moderate/severe*)? What are the most significant sources of stress in your life currently?

_____

Legal History: If your current symptoms are a result of an injury, are you currently involved in a lawsuit? (Y/N) If yes, what is the current status of the lawsuit?

_____

What do you do to help relieve stress? _____

What do you do for fun and/or to relax? _____

Current Examination:

Is there anything else that you want the examiner to know or that is particularly relevant to your neuropsychological evaluation?

_____

_____

Do you have any specific concerns about this evaluation?

_____

_____

THANK YOU